HOUSE BILL NO. 331

INTRODUCED BY WANZENRIED, TESTER, GILLAN, R. BROWN, ROBERTS

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR MEDICAL MALPRACTICE INSURANCE WHEN THE INSURANCE IS NOT REASONABLY AVAILABLE; ~~AND~~ CREATING AN ASSOCIATION CONSISTING OF ~~ALL~~ CERTAIN ~~CASUALTY~~ ~~MEDICAL MALPRACTICE~~ CASUALTY INSURERS TO PROVIDE THE INSURANCE; PROVIDING A PROCESS FOR DETERMINING AVAILABILITY OF MEDICAL MALPRACTICE INSURANCE; CREATING A STABILIZATION RESERVE FUND; AND AMENDING SECTION 33-11-105, MCA."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Purpose.** The legislature finds that IF a crisis exists because of the potential unavailability of medical malpractice insurance caused by carrier withdrawals from the Montana market, carrier insolvency, underwriting practices of existing carriers, high cost ~~and lack of affordability~~, and other reasons not attributable to neglect, oversight, or willfulness of a prospective policyholder, ALTERNATIVE PROGRAMS SHOULD BE EMPLOYED TO HELP ENSURE THAT MEDICAL MALPRACTICE INSURANCE REMAINS AVAILABLE TO MONTANA HEALTH CARE PROVIDERS AND HEALTH CARE FACILITIES. The purpose of [sections 1 through ~~14~~ 20] is to provide a solution to the unavailability of medical malpractice insurance. Although [sections 1 through ~~14~~ 20] will not resolve the underlying causes of unavailability and high cost, which extend beyond the insurance mechanism, it is anticipated that future legislation will deal on a more permanent basis with the root causes of the current crisis.

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through ~~14~~ 20], the following definitions apply:

(1) "Association" means the joint underwriting association established pursuant to the provisions of [sections 1 through ~~14~~ 20].

(2) "COMMITTEE" MEANS A COMMITTEE DESIGNATED BY THE COMMISSIONER TO COORDINATE THE ACTIVITIES OF THE MARKET ASSISTANCE PLAN AND COMPOSED OF LICENSED INSURANCE PRODUCERS, INSURERS AUTHORIZED TO SELL MEDICAL MALPRACTICE INSURANCE IN THIS STATE, AND ELIGIBLE SURPLUS LINES INSURERS.

~~(2)~~(3) "Health care provider" has the meaning provided in 27-6-103.

(4) "MARKET ASSISTANCE PLAN" MEANS A VOLUNTARY MECHANISM OPERATED BY A COMMITTEE TO ASSIST HEALTH CARE PROVIDERS AND HEALTH CARE FACILITIES TO BUY MEDICAL MALPRACTICE INSURANCE WHEN MEDICAL MALPRACTICE INSURANCE IS NOT REASONABLY AVAILABLE IN THE VOLUNTARY MARKET.

~~(3)~~(5) "Medical malpractice insurance" means insurance coverage against the legal liability of the insured and against loss, damage, or expense incident to a claim arising out of the death of or injury to any person as the result of negligence in rendering professional service by a health care provider.

~~(4)~~(6) "Net direct premiums" means gross direct premiums on ~~casualty~~ ~~MEDICAL MALPRACTICE~~ CASUALTY insurance, EXCLUDING ~~PREMIUMS ON PROFESSIONAL MALPRACTICE INSURANCE AND~~ PREMIUMS WRITTEN BY A RISK RETENTION GROUP AS DEFINED IN 33-11-102, written pursuant to the provisions of the insurance laws of Montana, including the liability component of multiple-peril package policies as computed by the commissioner, less return premiums or the unused or unabsorbed portions of premium deposits.

(7) "VOLUNTARY MARKET" MEANS INSURERS AUTHORIZED TO WRITE MEDICAL MALPRACTICE INSURANCE IN THIS STATE, CAPTIVE INSURERS AUTHORIZED TO WRITE MEDICAL MALPRACTICE INSURANCE IN THIS STATE, AND ELIGIBLE SURPLUS LINES INSURERS, IF APPROVED BY THE COMMISSIONER BASED ON FINANCIAL STABILITY OF THE SURPLUS LINES INSURER AND THE COST AND COVERAGE OF THE MEDICAL MALPRACTICE POLICIES AVAILABLE FROM THE SURPLUS LINES INSURERS.

NEW SECTION. **SECTION 3. MARKET REVIEW.** (1) AFTER PROVIDING NOTICE TO ALL INSURERS ELIGIBLE TO SELL MEDICAL MALPRACTICE INSURANCE IN THIS STATE, INCLUDING ELIGIBLE SURPLUS LINES INSURERS, THE COMMISSIONER SHALL PERFORM A MARKET REVIEW TO DETERMINE THE AVAILABILITY OF MEDICAL MALPRACTICE INSURANCE BEFORE IMPLEMENTING A MARKET ASSISTANCE PLAN UNDER [SECTION 4] OR A JOINT UNDERWRITING ASSOCIATION UNDER [SECTION 5].

(2) THE COMMISSIONER SHALL COMPILE A LIST OF INSURERS IN THE VOLUNTARY MARKET.

(3) AFTER HOLDING A HEARING, THE COMMISSIONER SHALL DETERMINE WHETHER MEDICAL MALPRACTICE INSURANCE IS REASONABLY AVAILABLE PURSUANT TO SUBSECTION (4) FOR:

(A) HEALTH CARE PROVIDERS, OTHER THAN HEALTH CARE FACILITIES; OR

(B) HEALTH CARE FACILITIES.

(4) IN DETERMINING WHETHER MEDICAL MALPRACTICE INSURANCE IS REASONABLY AVAILABLE, THE COMMISSIONER SHALL CONSIDER WHETHER:

(A) THERE IS A SIGNIFICANT LIKELIHOOD OF A LACK OF AVAILABLE HEALTH CARE SERVICES TO THE PUBLIC

BECAUSE OF THE COST OR UNAVAILABILITY OF MEDICAL MALPRACTICE INSURANCE;

(B) A SIGNIFICANT PORTION OF THE MEMBERS OF A CLASS OF HEALTH CARE PROVIDERS:

(I) CANNOT OBTAIN MEDICAL MALPRACTICE INSURANCE FROM MEDICAL MALPRACTICE INSURERS FOR REASONS NOT ATTRIBUTABLE TO NEGLIGENCE, NEGLECT, OVERSIGHT, OR WILLFULNESS OF THE HEALTH CARE PROVIDERS; OR

(II) IS UNINSURED AS A RESULT OF NEW UNDERWRITING RESTRICTIONS UNRELATED TO THE ACTS OR OMISSIONS OF THE HEALTH CARE PROVIDERS OR BECAUSE OF THE INSOLVENCY OF A MEDICAL MALPRACTICE INSURER.

NEW SECTION. **SECTION 4. MARKET ASSISTANCE PLAN.** (1) IF THE COMMISSIONER DETERMINES UNDER [SECTION 3] THAT MEDICAL MALPRACTICE INSURANCE IS NOT REASONABLY AVAILABLE, THE COMMISSIONER SHALL ATTEMPT TO FORM A MARKET ASSISTANCE PLAN FOR MEDICAL MALPRACTICE INSURANCE BEFORE IMPLEMENTING A JOINT UNDERWRITING ASSOCIATION UNDER [SECTION 5].

(2) THE COMMISSIONER MAY ESTABLISH A MARKET ASSISTANCE PLAN ONLY IF THE COMMISSIONER DETERMINES THAT THERE EXISTS A SUFFICIENT NUMBER OF INSURERS IN THE VOLUNTARY MARKET WILLING TO UNDERWRITE STANDARD RISKS AT ADEQUATE COVERAGE LIMITS.

(3) IF AN INSURER IN THE VOLUNTARY MARKET DECLINES TO PARTICIPATE IN THE MARKET ASSISTANCE PLAN, THE INSURER SHALL STATE BOTH THE BUSINESS AND THE FINANCIAL REASONS FOR NOT PARTICIPATING IN THE MARKET ASSISTANCE PLAN.

(4) THE COMMISSIONER, IN CONSULTATION WITH THE COMMITTEE, SHALL DEVELOP A PLAN OF OPERATION FOR THE MARKET ASSISTANCE PLAN.

(5) THE MARKET ASSISTANCE PLAN MAY INCLUDE A REASONABLE PROCESSING FEE TO APPLICANTS THAT SEEK MEDICAL MALPRACTICE INSURANCE COVERAGE THROUGH THE MARKET ASSISTANCE PLAN.

(6) LICENSED INSURANCE PRODUCERS MAY RECEIVE A REASONABLE COMMISSION FOR MEDICAL MALPRACTICE INSURANCE PLACED IN THE MARKET ASSISTANCE PLAN. THE PLAN OF OPERATION MAY ALLOW A COMMISSION TO BE PAID REGARDLESS OF WHETHER THE PRODUCER IS APPOINTED OR OTHERWISE REPRESENTS THE INSURER ACCEPTING THE RISK.

NEW SECTION. **Section 5. Joint underwriting association ~~-- determination of unavailability of medical malpractice insurance~~.** (1) A joint underwriting association is created, consisting of all insurers authorized to write ~~and~~ ~~OR~~ ~~AND~~ OR engaged in writing ~~casualty~~ ~~MEDICAL MALPRACTICE~~ CASUALTY insurance within this state, including insurers writing multiple-peril package policies BUT EXCLUDING ~~INSURERS WRITING~~

~~PROFESSIONAL MALPRACTICE INSURANCE AND~~ RISK RETENTION GROUPS. Each insurer shall remain a member of the association as a condition of the insurer's authority to continue to write ~~casualty~~ ~~MEDICAL MALPRACTICE~~ CASUALTY insurance in this state. The purpose of the association is to provide medical malpractice insurance on a self-supporting basis.

(2) The association may not commence underwriting operations for health care providers, other than health care facilities, until the commissioner~~, after an investigation and hearing, has determined that medical malpractice insurance is not reasonably available for health care providers, other than health care facilities, in the voluntary market OR WITH AN ELIGIBLE SURPLUS LINES INSURER. Upon that determination, the association members~~ HAS CONDUCTED A MARKET REVIEW UNDER [SECTION 3], DETERMINED THAT MEDICAL MALPRACTICE INSURANCE IS NOT REASONABLY AVAILABLE FOR HEALTH CARE PROVIDERS, OTHER THAN HEALTH CARE FACILITIES, IN THE VOLUNTARY MARKET, AND ATTEMPTED TO ESTABLISH A MARKET ASSISTANCE PLAN. UPON THE COMMISSIONER DETERMINING THAT THE MARKET ASSISTANCE PLAN HAS NOT ACHIEVED REASONABLY AVAILABLE MEDICAL MALPRACTICE INSURANCE, THE COMMISSIONER SHALL NOTIFY THE ASSOCIATION THAT IT may issue policies of medical malpractice insurance to health care providers, other than health care facilities~~, but the~~. THE association need not be the exclusive agency through which medical malpractice insurance may be written in this state on a primary basis for health care providers, other than health care facilities.

(3) The association may not commence underwriting operations for health care facilities until the commissioner~~, after an investigation and hearing, has determined that medical malpractice insurance is not reasonably available for those facilities in the voluntary market OR WITH AN ELIGIBLE SURPLUS LINES INSURER. Upon that determination, the association members are authorized to~~ HAS CONDUCTED A MARKET REVIEW UNDER [SECTION 3], DETERMINED THAT MEDICAL MALPRACTICE INSURANCE IS NOT REASONABLY AVAILABLE FOR THOSE FACILITIES IN THE VOLUNTARY MARKET, AND ATTEMPTED TO ESTABLISH A MARKET ASSISTANCE PLAN. UPON THE COMMISSIONER DETERMINING THAT THE MARKET ASSISTANCE PLAN HAS NOT ACHIEVED REASONABLY AVAILABLE MEDICAL MALPRACTICE INSURANCE, THE COMMISSIONER SHALL NOTIFY THE ASSOCIATION THAT IT MAY issue policies of medical malpractice insurance to health care facilities~~, but the~~. THE association need not be the exclusive agency through which medical malpractice insurance may be written in this state on a primary basis.

(4) If the commissioner determines at any time that medical malpractice insurance is reasonably available in the voluntary market ~~OR WITH AN ELIGIBLE SURPLUS LINES INSURER~~ for the health care providers referred to in either subsection (2) or (3), the association shall cease its underwriting operations for the medical malpractice insurance that the commissioner has determined is reasonably available in the voluntary market ~~OR~~

~~WITH AN ELIGIBLE SURPLUS LINES INSURER~~.

~~(5) Medical malpractice insurance is not reasonably available if the commissioner determines:~~

~~(a) that there is a significant likelihood of a lack of available health care services to the public because of the cost or unavailability of medical malpractice insurance;~~

~~(b) after a hearing on the matter, that premiums for a significant portion of the members of a class of health care providers have increased by 100% or more during the 36 months or less prior to the hearing; or~~

~~(c) that a significant portion of the members of a class of health care providers:~~

~~(i) cannot obtain medical malpractice insurance from medical malpractice insurers for reasons not attributable to negligence, neglect, oversight, or willfulness of the health care providers; or~~

~~(ii) are uninsured as a result of new underwriting restrictions unrelated to the acts or omissions of the health care providers or because of the insolvency of a medical malpractice insurer.~~

(5) THE ASSOCIATION MAY OPERATE FOR A PERIOD OF 3 YEARS. AT THE END OF THE 3-YEAR PERIOD, THE ASSOCIATION MUST BE DISSOLVED UNLESS THE COMMISSIONER, AFTER NOTICE AND A HEARING, REAUTHORIZES THE OPERATIONS OF THE ASSOCIATION. IF THE COMMISSIONER DETERMINES THAT ADEQUATE MEDICAL MALPRACTICE INSURANCE IS AVAILABLE IN THE VOLUNTARY MARKET, THE COMMISSIONER SHALL ORDER THE ASSOCIATION TO END ITS UNDERWRITING OPERATIONS AND SHALL SUPERVISE THE DISSOLUTION OF THE ASSOCIATION, INCLUDING SETTLEMENT OF ALL FINANCIAL AND LEGAL OBLIGATIONS AND DISTRIBUTION OF ANY REMAINING ASSETS.

NEW SECTION. **Section 6. Authority to issue policies.** The association may:

(1) subject to limits specified in the association's plan of operation, but not to exceed ~~$3~~ $2 million for each claimant under one policy and ~~$9~~ $4 million for all claimants under one policy in any 1 year, issue or cause to be issued policies of medical malpractice insurance to applicants, including incidental coverages;

(2) underwrite the medical malpractice insurance and assume reinsurance from its members; and

(3) cede reinsurance.

NEW SECTION. **Section 7. Plan of operation -- submission -- amendment.** (1) Within 45 days after the creation of the association, the board of directors of the association shall submit to the commissioner for the commissioner's review a proposed plan of operation consistent with the provisions of [sections 1 through ~~14~~ 20]. The plan is effective upon order of the commissioner.

(2) The plan of operation must provide for economic, fair, and nondiscriminatory administration and for

the prompt and efficient provision of medical malpractice insurance. The plan must contain a preliminary assessment against all members for initial expenses necessary to commence operations and establish necessary facilities and an annual assessment against all members for the costs of managing the association, losses and expenses, commission arrangements, reasonable and objective underwriting standards, acceptance and cession of reinsurance, appointment of servicing carriers, and procedures for determining amounts of medical malpractice insurance to be provided by the association.

(3) The plan of operation must provide that the ~~final~~ premium for all policyholders of the association, as a group, must be equal to the administrative expenses, loss, loss adjustment expenses, and taxes, plus a reasonable allowance for contingencies and servicing. Policyholders must be given full credit for all association investment income, after deduction of association expenses and a reasonable management fee, on policyholder premiums.

(4) Amendments to the plan of operation may be made by the board of directors of the association, subject to the approval of the commissioner~~, or by the commissioner~~.

NEW SECTION. **Section 8. Application for coverage.** (1) After a determination of unavailability is made under [section ~~3(2)~~ 5(2) or (3)], a health care provider may apply to the association for coverage. The application may be made on behalf of an applicant by a broker or agent authorized by the applicant.

(2) If the association determines that the applicant meets the underwriting standards of the association as prescribed in the plan of operation and that there is no unpaid, uncontested premium due from the applicant for prior medical malpractice insurance, as shown by the insured having failed to make written objections to the premium charges within 30 days after billing, then ~~an~~ THE association ~~member~~, upon receipt of the premium or the portion of the premium that is prescribed in the plan of operation, shall issue a policy of medical malpractice insurance for a term of 1 year.

NEW SECTION. **Section 9. Rates -- approval ~~-- recoupment of deficit~~.** (1) The rates, rating plans, rating rules, rating classifications, territories, policy forms applicable to the medical malpractice insurance written by the association ~~members~~, and related statistics ~~are subject to the insurance laws of Montana, giving~~ PURSUANT TO 33-1-501, 33-1-502, AND TITLE 33, CHAPTER 16, MUST GIVE consideration to the past and prospective loss and expense experience for medical malpractice insurance of ~~the members of~~ the association, trends in the frequency and severity of losses, the investment income of the ~~members~~ ASSOCIATION, and other information

that the commissioner may require.

(2) Within the time directed by the commissioner, the association shall submit ~~for the approval of the commissioner~~ an initial filing of policy forms, classifications, rates, rating plans, and rating rules applicable to medical malpractice insurance to be written by the association ~~members. If the commissioner disapproves the initial filing in whole or in part, the association shall amend it in accordance with the direction of the commissioner~~ PURSUANT TO 33-1-501, 33-1-502, AND TITLE 33, CHAPTER 16.

~~(3) Any deficit sustained by the association must be recouped pursuant to the plan of operation and the rating plan then in effect by one or more of the following procedures:~~

~~(a) an assessment upon the members, as provided in [section 10];~~

~~(b) a premium rate increase ON THE ASSOCIATION'S POLICYHOLDERS applicable prospectively;~~

~~(c) a premium contingency assessment on the ASSOCIATION'S policyholders, as provided in [section 8].~~

~~(4)~~(3) After the initial year of operation, rates, rating plans, rating rules, and any provision for recoupment through member assessment or a premium rate increase must be based upon the ~~association members'~~ ASSOCIATION'S loss and expense experience, together with other information based upon that experience that the commissioner considers appropriate. Any resulting member assessment or a premium rate increase must be on an actuarially sound basis and be calculated to make the association self-supporting.

NEW SECTION. **SECTION 10. RECOUPMENT OF DEFICIT AND MEMBER ASSESSMENTS.** (1) (A) IF THE ASSOCIATION EXPERIENCES AN UNDERWRITING DEFICIT FOR ANY YEAR, THE DEFICIT MUST BE RECOUPED AS PROVIDED IN THE PLAN OF OPERATION AND THE RATING PLAN MUST CONTAIN THE PROCEDURES PROVIDED FOR IN SUBSECTIONS (1)(B) AND (1)(C).

(B) THE BOARD OF DIRECTORS SHALL CERTIFY THE UNDERWRITING DEFICIT TO THE COMMISSIONER. THE CERTIFICATION IS SUBJECT TO THE REVIEW OF THE COMMISSIONER.

(C) AFTER REVIEW OF THE CERTIFICATION, THE DEFICIT MUST BE RECOUPED BY:

(I) FIRST, REIMBURSEMENT OF THE DEFICIT IN THE FOLLOWING ORDER:

(A) FROM THE STABILIZATION RESERVE FUND, AS PROVIDED IN [SECTION 11];

(B) A PREMIUM CONTINGENCY ASSESSMENT ON THE ASSOCIATION'S POLICYHOLDERS, AS PROVIDED IN [SECTION 12], IF THE REIMBURSEMENT IN SUBSECTION (1)(C)(I)(A) IS INSUFFICIENT; AND

(C) AN ASSESSMENT UPON THE MEMBERS, AS PROVIDED IN [SECTION 15], IF THE REIMBURSEMENT IN SUBSECTIONS (1)(C)(I)(A) AND (1)(C)(I)(B) IS INSUFFICIENT; AND

(II) SECOND, A PREMIUM RATE INCREASE ON THE ASSOCIATION'S POLICYHOLDERS APPLICABLE PROSPECTIVELY, AS PROVIDED IN [SECTION 9].

(2) REIMBURSEMENTS FROM THE STABILIZATION RESERVE FUND AND PREMIUM CONTINGENCY ASSESSMENTS IMPOSED UNDER THIS SECTION AND PREMIUMS COLLECTED UNDER [SECTIONS 9 AND 16] AND SUBSECTION (1)(C)(II) OF THIS SECTION MUST BE SUFFICIENT TO RECOUP ALL EXPENSES OF THE ASSOCIATION AND TO REIMBURSE THE MEMBERS FOR ALL ASSESSMENTS IMPOSED ON THEM BY THE ASSOCIATION.

NEW SECTION. **SECTION 11. STABILIZATION RESERVE FUND.** (1) THE COMMISSIONER SHALL ESTABLISH A STABILIZATION RESERVE FUND.

(2) (A) EACH POLICYHOLDER SHALL PAY TO THE ASSOCIATION A STABILIZATION RESERVE FUND CHARGE EQUAL TO 15% OF EACH PREMIUM PAYMENT DUE FOR INSURANCE THROUGH THE ASSOCIATION. THE STABILIZATION RESERVE FUND CHARGE MUST BE STATED SEPARATELY IN THE POLICY AND IS PAYABLE WITH EACH PREMIUM PAYMENT. THE ASSOCIATION SHALL CANCEL THE POLICY OF ANY POLICYHOLDER WHO FAILS TO PAY THE PREMIUM STABILIZATION RESERVE FUND CHARGE.

(B) THE STABILIZATION RESERVE FUND CHARGE DOES NOT CONSTITUTE A PART OF THE PREMIUM AND IS NOT SUBJECT TO PREMIUM TAXATION, SERVICING FEES, ACQUISITION COSTS, COMMISSIONS, OR ANY OTHER CHARGES. THE STABILIZATION RESERVE FUND CHARGE MAY NOT BE CONSIDERED A PREMIUM FOR THE PURPOSE OF ANY ASSESSMENTS LEVIED UNDER [SECTION 15].

(3) (A) THE ASSOCIATION SHALL COLLECT AND ADMINISTER THE STABILIZATION RESERVE FUND CHARGE. THE STABILIZATION RESERVE FUND CHARGE MUST BE TREATED AS A LIABILITY OF THE ASSOCIATION ALONG WITH AND IN THE SAME MANNER AS PREMIUM AND LOSS RESERVES.

(B) ALL MONEY RECEIVED BY THE STABILIZATION RESERVE FUND MUST BE HELD IN TRUST BY A CORPORATE TRUSTEE SELECTED BY THE ASSOCIATION. THE CORPORATE TRUSTEE MAY INVEST THE MONEY HELD IN TRUST, SUBJECT TO THE APPROVAL OF THE ASSOCIATION. ALL INVESTMENT INCOME MUST BE CREDITED TO THE STABILIZATION RESERVE FUND. ALL EXPENSES OF ADMINISTRATION OF THE STABILIZATION RESERVE FUND MUST BE CHARGED AGAINST THE FUND. THE MONEY HELD IN TRUST MAY BE USED ONLY FOR THE PURPOSE OF RECOUPMENT OF ANY DEFICIT SUSTAINED BY THE ASSOCIATION, AS PROVIDED IN [SECTION 10].

(C) COLLECTIONS OF THE STABILIZATION RESERVE FUND CHARGE CONTINUE THROUGHOUT EACH CALENDAR YEAR FOR WHICH THE FUND IS ESTABLISHED. HOWEVER, A CHARGE MAY NOT BE ASSESSED:

(I) DURING THE NEXT SUCCEEDING CALENDAR YEAR IF THE NET BALANCE IN THE STABILIZATION RESERVE FUND

AFTER RECOUPMENT OF ANY PRIOR YEAR'S DEFICIT EQUALS OR EXCEEDS THE ASSOCIATION'S ESTIMATE OF THE PROJECTED SUM OF PREMIUMS TO BE WRITTEN IN THE CALENDAR YEAR FOLLOWING THE VALUATION DATE OF THE FUND; OR

(II) IN ANY YEAR IN WHICH A PREMIUM CONTINGENCY ASSESSMENT IS COLLECTED, AS PROVIDED IN [SECTION 12].

(4) THE STABILIZATION RESERVE FUND CHARGE IS NOT REFUNDABLE IF THE POLICY IS CANCELED AFTER THE 90TH DAY OF COVERAGE.

(5) UPON DISSOLUTION OF THE ASSOCIATION AS PROVIDED IN [SECTION 5(5)], THE COMMISSIONER SHALL ORDER THAT ANY FUNDS REMAINING IN THE STABILIZATION RESERVE FUND BE REIMBURSED TO THE POLICYHOLDERS IN PROPORTION TO THE AMOUNTS OF THE STABILIZATION RESERVE FUND CHARGES PAID BY THE POLICYHOLDERS.

NEW SECTION. **Section 12. Premium contingency assessment to cover deficit.** (1) If the association suffers an underwriting deficit for any year~~, the board of directors shall certify that fact to the commissioner. The certification is subject to the review and approval of the commissioner. As provided in the plan of operation, but for a period not to exceed 1 year, each policyholder~~ OF THE ASSOCIATION'S POLICYHOLDERS AND RECOUPMENT OF THE UNDERWRITING DEFICIT BY REIMBURSEMENT, AS PROVIDED IN [SECTION 10(1)(C)(I)(A)], IS INSUFFICIENT, EACH ASSOCIATION POLICYHOLDER shall pay to the association a premium contingency assessment ~~that bears~~ AS PROVIDED IN THE PLAN OF OPERATION. THE ASSESSMENT MUST BEAR the same ratio to the amount of the deficit as the policyholder's premium for the year for medical malpractice insurance written or reinsured by the association bore to the total premiums paid to the association for the year. The association may cancel any policy of any policyholder who fails to pay the premium contingency assessment and need not DEFEND OR pay any future claims against that policyholder. A deficit premium contingency assessment that cannot be collected from a policyholder may not be assessed against any other policyholder ~~or policyholders. THE COMMISSIONER SHALL ENSURE THAT A PREMIUM CONTINGENCY ASSESSMENT IMPOSED UPON POLICYHOLDERS UNDER [SECTION 7] AND THIS SECTION OR A PREMIUM RATE INCREASE IMPOSED ON THE POLICYHOLDERS UNDER [SECTION 7] IS SUFFICIENT TO ULTIMATELY COVER ALL EXPENSES OF THE ASSOCIATION DESCRIBED IN [SECTION 5(3)] AND TO REIMBURSE THE MEMBERS FOR ALL ASSESSMENTS IMPOSED ON THEM BY THE ASSOCIATION.~~

~~(2) A deficit incurred by the association may not be charged directly or indirectly to any insured other than a policyholder insured through the association.~~

~~(3)~~(2) The association shall amend the amount of its certification of deficit to the commissioner as the value of its incurred losses becomes finalized, and ~~the members of~~ the association ~~shall, upon approval by the~~

~~commissioner~~, MAY amend ~~their~~ ITS recoupment procedure accordingly.

(3) The board of directors may require all members to contribute on a temporary basis to the financial requirements of the association prior to recoupment of any deficit in the proportion specified in the plan.

(4) THE ASSOCIATION MAY NOT COLLECT STABILIZATION RESERVE ASSESSMENTS, AS PROVIDED IN [SECTION 11], IN ANY YEAR IN WHICH PREMIUM CONTINGENCY ASSESSMENTS ARE COLLECTED UNDER THIS SECTION.

NEW SECTION. **Section 13. Claims-made policies ~~and occurrence-based policies~~.** The ASSOCIATION SHALL OFFER POLICIES ON A CLAIMS-MADE BASIS. ~~commissioner shall require the association members to offer policies on both a claims-made and occurrence basis so that applicants may select either policy at their option.~~ The premiums charged for ~~both~~ claims-made ~~and occurrence-based~~ policies must be established on an actuarially sound basis AND AS PROVIDED IN TITLE 33, CHAPTER 16.

NEW SECTION. **SECTION 14. RISK MANAGEMENT.** (1) THE ASSOCIATION SHALL ESTABLISH A RISK MANAGEMENT PROGRAM FOR PERSONS OR ENTITIES INSURED BY THE ASSOCIATION.

(2) THE RISK MANAGEMENT PROGRAM MUST INCLUDE:

(A) STANDARDS FOR SYSTEMATIC INVESTIGATION AND REPORTING OF CLAIMS AND INCIDENTS; AND

(B) A LOSS CONTROL PROGRAM. THE LOSS CONTROL PROGRAM MUST INCLUDE PROCEDURES FOR:

(I) ANALYSIS OF CLAIM FREQUENCY, SEVERITY, AND CAUSES OF LOSS;

(II) IDENTIFICATION OF SITUATIONS THAT MAY PRODUCE LARGE LOSSES;

(III) DEVELOPMENT OF MEASURES TO CONTROL LOSSES;

(IV) MONITORING OF THE EFFECTIVENESS OF THE LOSS CONTROL MEASURES THAT ARE IMPLEMENTED; AND

(V) EDUCATION OF INSURED HEALTH CARE PROVIDERS AND HEALTH CARE FACILITIES ON METHODS TO REDUCE OR PREVENT LOSSES.

(3) THE COMMISSIONER SHALL APPOINT AN ADVISORY COUNCIL CONSISTING OF THREE HEALTH CARE PROVIDERS AND THREE PROFESSIONAL INSURANCE RISK MANAGERS TO PROVIDE ADVICE TO THE ASSOCIATION ON RISK MANAGEMENT ACTIVITIES.

NEW SECTION. **Section 15. Financial participation by association members.** (1) Each member of the association shall participate in the association's medical malpractice insurance policies, expenses, profits, and losses in the proportion that the net direct premiums of the member during the preceding calendar year,

after excluding that portion of premiums attributable to the operation of the association, bears to the aggregate net direct premiums of all members of the association.

(2) Each member's participation in the association must be determined annually on the basis of the net direct premiums written during the preceding calendar year as reported in the annual statements and other reports filed by the insurer with the commissioner.

(3) A member is not obligated to reimburse the association for the member's proportionate share in a deficit from operations of the association in ~~a given year in excess of 1% of the member's surplus to policyholders, and the~~ ANY CALENDAR YEAR IN AN AMOUNT GREATER THAN 1% OF THE MEMBER'S NET DIRECT WRITTEN PREMIUM FOR THE PRECEDING CALENDAR YEAR ON POLICIES WRITTEN IN THIS STATE FOR CASUALTY INSURANCE. THE aggregate amount not reimbursed must be reallocated among the remaining members in accordance with the method of determining participation after excluding from the computation the total net direct premiums of all members not sharing in the excess deficit. If the deficit from operations allocated to all members of the association ~~for a~~ IN ANY calendar year exceeds 1% of ~~their respective surpluses to policyholders~~ THE MEMBER'S NET DIRECT WRITTEN PREMIUM FOR THE PRECEDING CALENDAR YEAR ON POLICIES WRITTEN IN THIS STATE FOR CASUALTY INSURANCE, the amount of the deficit must be allocated to each member in accordance with the method of determining participation. A MEMBER MAY NOT BE ASSESSED AN AMOUNT THAT WOULD JEOPARDIZE THAT MEMBER'S SOLVENCY.

NEW SECTION. **SECTION 16. RECOGNITION OF ASSESSMENTS IN RATES.** THE RATES AND PREMIUMS CHARGED FOR INSURANCE POLICIES TO WHICH [SECTIONS 1 THROUGH 20] APPLY MUST INCLUDE AMOUNTS SUFFICIENT TO RECOUP A SUM EQUAL TO THE AMOUNTS PAID TO THE ASSOCIATION BY THE MEMBER LESS ANY AMOUNTS RETURNED TO THE MEMBER BY THE ASSOCIATION, AND THESE RATES MAY NOT BE CONSIDERED EXCESSIVE BECAUSE THEY CONTAIN AN AMOUNT REASONABLY CALCULATED TO RECOUP ASSESSMENTS PAID BY THE MEMBER.

NEW SECTION. **Section 17. Directors.** The association must be governed by an annually elected board of directors. Eight directors must be elected by cumulative voting of members of the association, whose votes must be weighted in the proportion that a member's net direct premiums during the preceding calendar year bears to the net direct premiums of all the members during the preceding calendar year. Three directors must be appointed by the commissioner as representatives of the medical profession, and the appointments must be made at or before each annual meeting. The eight directors serving on the first board who are to be

elected by members of the association must be elected at a meeting of the members held at a time and place designated by the commissioner.

NEW SECTION. **Section 18. Appeals and judicial review.** For matters that the law or the plan of operation defines as appealable, an applicant for medical malpractice insurance, ~~insurer person, or insurer~~ INSURED HEALTH CARE PROVIDER OR HEALTH CARE FACILITY, OR ASSOCIATION MEMBER may appeal to the commissioner within 30 days after a decision by or on behalf of the association. An order of the commissioner is subject to judicial review as provided in Title 33.

NEW SECTION. **Section 19. Annual statements.** The association shall file in the office of the commissioner on or before March 1 of each year a statement containing information with respect to the association's transactions, condition, operations, and affairs during the preceding calendar year. The statement must contain the matters and information and be in the format prescribed by the commissioner. The commissioner may at ~~any~~ THAT time require the association to furnish additional information that the commissioner believes to be material and of assistance in evaluating the scope, operation, and experience of the association.

NEW SECTION. **Section 20. Examination of association's affairs.** The commissioner shall examine the affairs of the association at least annually.

SECTION 21. SECTION 33-11-105, MCA, IS AMENDED TO READ:

"33-11-105. Compulsory associations. (1) A risk retention group may not join or contribute financially to any insurance insolvency guaranty fund or similar mechanism in this state. In addition, a risk retention group or its insureds may not receive any benefit from any guaranty fund for claims arising out of the operations of the risk retention group.

(2) (a) ~~A~~ Except as provided in subsection (2)(b), a risk retention group shall participate in this state's joint underwriting associations, mandatory liability pools, and similar mechanisms.

(b) A risk retention group is excluded from participating in the joint underwriting association provided for in [section 5] and related financing mechanisms.

(3) When a purchasing group obtains insurance covering its members' risks from an insurer not

authorized in this state or from a risk retention group, the risks, wherever resident or located, may not be covered by any insurance guaranty fund or similar mechanism in this state.

(4) When a purchasing group obtains insurance covering its members' risks from an authorized insurer, only risks resident or located in this state may be covered by the state guaranty fund, subject to Title 33, chapter 10, part 1."

NEW SECTION. **Section 22. Codification instruction.** [Sections 1 through ~~14~~ 20] are intended to be codified as an integral part of Title 33, chapter 23, and the provisions of Title 33 apply to [sections 1 through ~~14~~ 20].

- END -